BILL ANALYSIS

Senate Research Center
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H.B. 1592
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Health & Human Services
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Engrossed

AUTHOR'S / SPONSOR'S STATEMENT OF INTENT

Surprise medical billing most commonly occurs with emergency departments, freestanding emergency rooms (FSERs), or when a facility-based physician or other practitioner does not have a contract with the same health plans that have contracted with the facility in which they practice. An enrollee who is admitted into one of these facilities for a procedure or an emergency often becomes ultimately responsible for an unexpected bill.

The 86th Legislature passed S.B. 1264, "relating to consumer protections against certain medical and health care billing by certain out-of-network providers," to establish a prohibition against surprise medical billing for Texas patients. This legislation took effect in January of 2020 and only applied to health insurance plans regulated by the Texas Department of Insurance. The law did not regulate health insurance plans that are self-funded, because those are regulated by Employee Retirement Income Security Act (ERISA) of 1974 federal laws.

In December 2020, the federal No Surprises Act passed, giving patients with self-funded, ERISA-regulated health insurance plans (a majority of insured Texans) protection from surprise medical billing. Texas law will not be preempted because the Texas law is considered a "specified state law" under the No Surprises Act and will continue to apply, with respect to state-regulated plans. This federal No Surprises Act is currently being litigated.

This legislation amends Texas surprise billing law to allow self-funded health insurance plans to opt into the Texas law rather than the federal No Surprises Act. The purpose of the legislation is to provide a choice to plan sponsors and employers when deciding which law they would like to be regulated by to protect their employees from surprise medical billing.

H.B. 1592 amends current law relating to the application of balance billing prohibitions and out-of-network dispute resolution procedures to certain self-insured or self-funded employee welfare benefit plans.

RULEMAKING AUTHORITY

Rulemaking authority is expressly granted to the commissioner of insurance in SECTION 2 of this bill.

SECTION BY SECTION ANALYSIS

SECTION 1. Amends Section 1275.002, Insurance Code, as follows:

> Sec. 1275.002. APPLICABILITY OF CHAPTER. Provides that Chapter 1275 (Balance Billing Prohibitions and Out-Of-Network Claim Dispute Resolution for Certain Plans) applies only to:
>
> (1) creates this subdivision from existing text; and
>
> (2) a health benefit plan:
>
> (A) that is a self-insured or self-funded plan established by an employer for the benefit of the employer's employees in accordance with the

Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.); and

(B) for which the plan sponsor has made an election, submitted to the commissioner of insurance (commissioner) in the form and manner prescribed by the commissioner, to apply this chapter to the plan for the relevant plan year.

SECTION 2. Requires the commissioner, not later than December 1, 2023, to adopt rules necessary to implement the change in law made by this Act.

SECTION 3. Effective date: September 1, 2023.